State of Maine
Children with Special Health Needs
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

# Authorization to Obtain Information

I understand that this Authorization to Obtain Information allows the Children's Special Health Needs (CSHN) Program to obtain health care information on my child to determine medical eligibility for the Program and to communicate both in writing, and verbally, with the providers who are working with my child. I understand that the information obtained by the CSHN Program will be kept confidential and will **only** be used to determine medical eligibility for the Program.

I understand that a photocopy and/or fax of this permission is good for twelve (12) months from the date the form is signed. I can cancel this permission at any time by sending the CSHN Program a written, signed and dated letter.

I have the right to refuse to disclose all or some healthcare information but I realize that this may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other health insurance or other adverse consequesnces for my child.

I hereby authorize the release of healthcare information to the Children with Special Health Needs Program for the purpose of determining my child's medical eligibility. This includes but is not limited to medical records, and telephone discussions with my child's providers.

I understand that the CSHN Program needs my written authorization to receive any information on my child that refers to the following: treatment or diagnosis of drug or alcohol abuse, treatment or diagnosis of mental health information, information that refers to HIV tests, infection status or treatment information.

_____ _____ _____

Child's Name | Date of Birth | Child's SS Number

_____ _____

Parent's/Guardian's Name (print) | Parent's/Guardian's Signature

_____

Date

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# Confidential Financial Statement

Child's Name: _____ DOB: _____

Parent's/Guardian's Name: _____SS#_____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

**Please complete the following section for every member of the household***

| Name | Birth date | Relationship to client | Health Status | Occupation/Employer |
|---|---|---|---|---|

*INCOME: Financial eligibility is based on the family's reported taxable income for the tax year prior to the application date. List all individuals living in the household and their wages. Please include a copy of the latest IRS forms.

| | Amount | How Often (circle one) | | |
|---|---|---|---|---|
| Wages of Father or Husband | _____ | Weekly | Monthly | Annually |
| Wages of Mother or Wife | _____ | Weekly | Monthly | Annually |
| Wages of Other Members of Household | _____ | Weekly | Monthly | Annually |
| Other Income Sources<br>Rental property, disability, unemployment<br>Worker's compensation, support payments<br>AFDC/TANIF | _____ | Weekly | Monthly | Annually |

TOTAL INCOME _____

I hereby certify that to the best of my knowledge the information that I have provided can be verified if requested.

Date: _____ Signature: _____

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## Medical Information

Please fill out the following information. This information will give us the names, contact information, and updated providers currently treating your child.

Child's Name: _____ Date of Birth: _____

Parent's/Guardian's Name: _____

Primary Diagnosis: _____ Gender: _____ Race: _____

| | Provider Name | Phone & Address | Last Appointment |
|---|---|---|---|
| **Primary Doctor:** | | | |
| **Specialist:** | | | |
| **Therapists:** | **OT** | | |
| | **PT** | | |
| | **ST** | | |
| **Child Development Services:** | | | |
| **Medications:** | | | |

**Immunizations up to date? Yes:** _____ **No:** _____ **Unsure:** _____

**Other:** _____

**Thank you for providing us with this important information!**

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## Third Party Insurance Information

Client Name: _____ DOB: _____

Parent's/Guardian's Name: _____ Phone: _____

Does this child receive MaineCare? Yes: _____ No: _____ MaineCare ID: _____

Is your child covered by health insurance? Yes: _____ No: _____

Is your child covered by any other health Insurance? Yes: _____ No: _____

If you answered yes to any of the above questions, please complete the following:

Name of Policy holder: _____ SSI# _____

Employer's Name: _____

Employers Address: _____

Insurance company: _____

Address: _____

Date Policy Began: _____ Date Policy Cancelled: _____

Group Number: _____ Certificate Number: _____

Prescription Card Company: _____

Address: _____

Group Number: _____ Policy Number: _____

Dental Insurance Company: _____

Address: _____

I understand and agree to reimburse the CSHN program the cost of all services paid by that program that are covered by my private insurance or if I receive any moneys from an accident, injury, or other incident that caused the injury or condition for which my child receives services from the Children with Special Health Needs Program.

I authorize the Department of Health and Human Services, Children with Special Health Needs program to exchange with any third party or provider of services only that information which is necessary for the purpose of administering the CSHN program in accordance with Federal and State requirements. I certify that the information on this form is true and correct to the best of my knowledge and belief.

Parent's/Guardian's signature: _____ Date: _____